SUPPLEMENT TO THE
BRITISH MEDICAL JOURNAL
LONDON SATURDAY DECEMBER 27 1947

WORLD MEDICAL ASSOCIATION

It will be remembered that the First Meeting of the General Assembly of the World Medical Association took place in Paris in September. It adopted as its objects the following:

(i) To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available.
(ii) To maintain the honour and protect the interests of the medical profession.
(iii) To study and report on the professional problems which confront the medical profession in the different countries.
(iv) To organize an exchange of information on matters of interest to the medical profession.
(v) To establish relations with, and to present the views of the medical profession to, the World Health Organization, Unesco, and other appropriate bodies.
(vi) To assist all peoples of the world to attain the highest possible level of health.
(vii) To promote world peace.

The Honorary Secretary (Dr. Charles Hill) has circulated the following letter to national medical associations indicating the main decisions of the Assembly pending the issue of the formal minutes.

Constitution

During the first part of the meeting, which took the form of a conference of representatives of national medical associations, various amendments were made in the draft articles and by-laws, which will now be revised in accordance with the decisions of the Conference and issued with the minutes. When the constitution thus amended was adopted by the Conference, it was formally declared that:

In the City of Paris at 3.40 p.m. on Sept. 18, 1947, the World Medical Association came into being.

The meeting then became the First Annual Meeting of the General Assembly, and Prof. Eugène Marquis (France) was installed as the first President of the Association. Dr. Charles Hill (Great Britain) was appointed Acting Honorary Secretary of the meeting.

Headquarters

It was decided that the offices of the Association should be situated in North America, the exact location being left for decision by the Council. One of the main factors influencing this decision was the desirability of close and constant contact with U.N. and W.H.O., which have their headquarters in New York.

Offer of Funds from U.S.A.

The delegates from the U.S.A. reported that certain industrial "friends of the American Medical Association," being convinced of the potential value of the World Medical Association to medicine and to the promotion of world peace, and being desirous of helping to establish it on a sound financial basis, had offered to guarantee an income of $50,000 for the first year and, if necessary, to continue a similar contribution for a further four years. The money was intended to be used for the provision of a permanent office, the remuneration of a full-time secretary and staff, and the running costs of the secretariat. An American committee of doctors and laymen had been set up to administer the funds. The American delegates emphasized that there was no intention of determining or interfering with the policy of the World Medical Association, the committee's only duty being to approve the general purpose of the scheme for which the Association desired to use the donors' money. After a prolonged discussion the Association decided by a majority to accept the generous offer of its American friends and adopted the following resolutions:

(i) That the General Assembly accept with gratitude the offer of the friends of the American Medical Association and place on record its deep appreciation of their generosity in making available funds sufficient for the establishment of the World Medical Association on a satisfactory basis.
(ii) That the funds thus made available be utilized to defray expenditure under the following headings: (*a*) the remuneration and expenses of the Secretary, other officials, and clerical staff; (*b*) the rent, rates, and other disbursements in connexion with the official headquarters; (*c*) the general office expenses of the headquarters office staff; (*d*) the cost of the publication of the Association's official bulletin or journal; (*e*) the travelling costs of the Council.
(iii) That the cost of the developments listed above be estimated at not more than $50,000 for the first year.
(iv) That the Council be authorized to act on the Assembly's behalf in appointing the Secretary of the World Medical Association and to make all other staffing arrangements, regional and other.
(v) That the Council be instructed to explore the possibility of making arrangements for gift funds to the World Medical Association to be made tax-free.
(vi) That member associations be recommended to consider the formation of W.M.A. supporting committees in their several countries.
(vii) That the Council be authorized to prepare plans of development, to enter into any necessary consultations, and to submit its proposals to the General Assembly.
(viii) That nothing in these resolutions shall diminish the authority of the General Assembly for the full control of the policy and affairs of the Association as provided in Article 8.

Subscription

The acceptance of the American offer does not, of course, relieve the Association of the necessity of collecting its own subscription income. After consideration of the Report of the Honorary Treasurer and of the possible methods of assessing subscriptions the General Assembly adopted the following resolutions:

(*a*) That the subscription of each member association be calculated at a flat rate per member with a minimum total and a maximum total.
(*b*) That the flat rate per member be 20 Swiss centimes, with a minimum of 1,000 Swiss francs and a maximum of 10,000 Swiss francs.

Membership Roll

In accordance with Article 5 (i) those national medical associations which were represented at the London Conference in September, 1946, were accepted as Founder Members. During 1946–7 the Organizing Committee, which was instructed by the Conference to proceed with the organization of the Association, invited all national medical associations to apply for membership, and those applicants which appeared to fulfil the conditions of Article 5 (ii) were accepted as members.

As soon as the constitution was adopted at the Paris meeting the procedure laid down in By-law 1 came into operation. Italy (La Federazione Nazionale degli Ordini dei Medici Italiani) made a written application for membership to the General Assembly and was accepted. Certain difficulties then arose in connexion with the associations in Latin America, and the General Assembly eventually decided to request the Council to submit for examination by next year's General Assembly the applications of all member associations.

Secretariat

As has been stated above, the General Assembly left to the Council the question of the general organization of the secretariat. It considered, however, the desire expressed by the Latin American associations for the specific recognition of the Spanish culture in the Association's organization. They proposed the adoption of Spanish as a third official language, and the appointment of a Spanish Assistant Secretary, whom they offered to finance without cost to the Association. The Assembly adopted the first proposal. With regard to the second it recognized that, with the development of the Association's work, it might become desirable to appoint perhaps several assistant secretaries in different parts of the world. It therefore instructed the Council to include this matter in its consideration of the general organization of the secretariat and recommended for acceptance the kind offer of the Latin American associations.

Proxy Voting in Assembly

The General Assembly referred to the Council for consideration a suggestion by Australia that provision should be made in the by-laws for voting by proxy in the General Assembly in order that far distant member associations, which might be unable to send delegates to a meeting of the General Assembly, should not thereby lose their voting power.

War Crimes

After a discussion of the motions on the agenda by Denmark and Great Britain and the British memorandum relating to the attitude of the profession to war crimes, and after hearing statements by members of the Assembly and by a French medical victim of war crimes, the Assembly appointed a small committee to formulate a recommendation. The following report of the committee was subsequently adopted by the Assembly:

(i) That a report on crimes committed since 1933 by doctors and medical organizations in Germany and other countries and on this violation of the medical ethic be prepared and made available to doctors throughout the world.

(ii) That the World Medical Association solemnly condemns the crimes against human beings committed by certain members of the medical profession such as are described in the British memorandum.

(iii) That every doctor at the time of receiving his medical degree or diploma be required to subscribe to the following oath: "My first duty, above all other duties, written or unwritten, shall be to care to the best of my ability for any person who is entrusted or entrusts himself to me, to respect his moral liberty, to resist any ill treatment that may be inflicted on him, and, in this connexion, to refuse my consent to any authority that requires me to ill-treat him. Whether my patient be my friend or my enemy, even in time of war or in internal disturbances, and whatever may be his opinions, his race, his party, his social class, his country, or his religion, my treatment and my respect for his human dignity will be unaffected by such factors."

(iv) That the World Medical Association endorse judicial action by which members of the medical profession who shared in war crimes are punished.

(v) That the World Medical Association request the German medical syndicates to make the following public declaration: (*a*) We, members of the German medical syndicate, are aware of the very large number of acts of cruelty committed both by individuals and collectively since 1933 in mental hospitals and in concentration camps and of the violation of the medical ethic. These acts have resulted in the death of some millions of people. A large number of our members have been implicated in these acts, either as instigators or as technical agents or as actual perpetrators. (*b*) We regret that the organized medical profession in Germany has not made any protest and has been content to ignore these acts, of which it could not have been unaware. (*c*) We undertake solemnly to condemn these crimes, to expel from our organization the criminals who have committed them, and to remind all our members of the respect due, not only to life, but to human personality, dignity, and liberty.

The Assembly instructed the Council to prepare a report incorporating these resolutions and also to take into consideration the following motion by the Netherlands:

That the Council be instructed to prepare a report on the collaboration of medical practitioners in the preparation of means of warfare.

Matters Referred to Council

During the course of the meeting the General Assembly also referred the following matters to the Council for appropriate action or investigation and report:

(i) The general arrangements for the organization and publication of a bulletin or journal; (ii) the preparation of a report on the inquiry into the present position of the medical profession in relation to the State; (iii) the motions of Luxembourg, supported by Australia, recommending the preparation of a comparative statement on standards of training for the medical profession and conditions of registration, and of a comparative statement on the qualifications of specialists; (iv) the following motions by India:

(*a*) That the Council be requested to study and report on the question of the advertisement of cures and medicines in the lay press; (*b*) That the Council be requested to study and report on the question of unqualified and unauthorized medical practice;

(v) the preparation of Standing Orders to govern the procedure of meetings of the General Assembly; (vi) the appointment of auditors.

Second Annual Meeting

The General Assembly decided to hold its 1948 meeting in Prague, the exact date being left to the Council to decide.

The General Assembly elected Dr. J. Stüchlick (Czechoslovakia) to preside over its Annual Meeting in 1948. He therefore becomes President-Elect for the year 1947–8. The General Assembly elected Dr. O. Leuch (Switzerland) as Treasurer of the Association for the period 1947–50.

Council 1947–8

The General Assembly elected the first Council. Dr. Zahor (Czechoslovakia) and Dr. Glorieux (Belgium) having resigned after election, the Council for 1947–8 is composed as follows:—Ex-officio President: Prof. E. Marquis (France); President-Elect: Dr. J. Stüchlick (Czechoslovakia); Treasurer: Dr. O. Leuch (Switzerland); Chairman: Dr. T. C. Routley (Canada); Vice-Chairman: Dr. D. Knutson (Sweden); Drs. L. H. Bauer (U.S.A.), J. A. Bustamante (Cuba), P. Cibrie (France), A. Hartwich (Australia), P. Z. King (China), J. A. Pridham (Great Britain), S. C. Sen (India), L. G. Tornel (Spain).

Meeting of Council

At the conclusion of the General Assembly's proceedings the Council held its first meeting. Pending the establishment of a permanent office and the appointment of a full-time secretary, the Council appointed Dr. Charles Hill (Great Britain) as Honorary Secretary of the Association, with temporary headquarters at B.M.A. House, London.

The Council will consider the conditions of service to be offered for a full-time secretary and will make arrangements for receiving and considering applications for the appointment. It hopes that national medical associations will make known in their countries the offer of the appointment so that the field for the selection of the right person may be as wide as possible.

In accordance with the General Assembly's acceptance of the principle of the appointment of assistant secretaries, Dr. Bustamante, Secretary of the Pan-American Medical Confederation, was appointed Honorary Assistant Secretary for matters pertaining to the Latin American countries.

I hope this brief note will give a general idea of the results of the First Annual Meeting and of the work which the Association is to undertake during the coming year. The World Medical Association is now an established organization, and the Council trusts that every national medical organization will give it its full support.

CHARLES HILL,
Honorary Secretary.

The Cheshire Protection of Practices Committee has issued a report summarizing its activities since the beginning of the war. The scheme resulted in a total of £98,418 being given to insurance practitioners serving with the Forces. The report pays tribute to the organizing ability of Mr. F. T. West, the Administrative Officer.

TERMS OF COMPENSATION FOR OFFICERS OF THE INDIAN MEDICAL SERVICE

The Armed Forces Committee has had under consideration the terms of compensation for officers of the Indian Medical Service which were announced by the Government in a White Paper in April of this year. Following correspondence with the Commonwealth Relations Office on a number of points arising out of these terms, a deputation of representatives of the Committee met senior officials of the C.R.O. on Oct. 10 to discuss points of criticism and obscurity arising from the White Paper. The following is a summary of the representations made by the Committee, and the replies of the C.R.O.

Basis of Compensation

The Committee commented on the fact that in the case of I.C.S. officers compensation was based on the completed years of service, whereas I.M.S. officers, in common with officers of the R.I.N. and I.A., have their compensation based on age. As there is considerable variation in the age of entry of officers of the I.M.S., the Committee recommended that where it can be shown that compensation based on age reacts to the disadvantage of an officer it should be possible for him to have his compensation based on years of service if the latter basis is more favourable.

The C.R.O. stated in reply that the difference in the bases of calculating compensation was due to the fact that in the I.C.S. the date of retirement was governed by years of service, whereas in the I.M.S. and other services it was governed by age. Moreover, while the age basis of compensation might in certain cases reduce compensation, it was equally true that if the years of service criterion were adopted for I.M.S. officers many would be penalized, particularly officers who entered the service late and had comparatively short service by the date of transfer of power. For example, an officer aged 39 with 9 years' service would have his compensation reduced from £6,000 to £3,375. It was further stated that at this stage it would be impossible to vary the basis of compensation.

Officers Retired before Aug. 15, 1947

The Committee considered that there was some case for compensation for officers who, in view of the impending change of government in India, had secured other employment before the appointed day.

In reply it was stressed by the C.R.O. that entitlement to compensation does not exist except in the case of officers who were serving on the day when power was transferred. The only exception to this is the special provision announced by the Viceroy on April 30, 1947 (*vide* para. 10 of the White Paper). An officer of the I.M.S., civil or military as the case may be, who was specially released by the Viceroy, or granted the requisite certificate of compulsory retirement by the commander-in-chief, in advance of the appointed date, remains entitled to compensation and proportionate pension. If an officer had left India on leave pending retirement before Aug. 15, 1947, and claimed that his retirement was compulsory as a result of the acceleration of the Indianization of the Armed Forces, special consideration would be given to his case, and if his claim were accepted by the Viceroy or the commander-in-chief in India under the provisions referred to above he would be eligible for compensation. Save in these exceptional cases, the grant of compensation is not admissible to any officer who proceeded on leave preparatory to retirement before Aug. 15, 1947.

The Committee understands that as a result of the acceleration of the transfer of power the number of officers who took up other employment before the appointed day is very small. In fact only one such case has been brought to the Committee's notice, and in this case the officer concerned was aware that his acceptance of the appointment was likely to jeopardize his claim to compensation.

Transfer of I.M.S. Officers to British Armed Services

The Committee sought further information about the C.R.O.'s intention regarding the transfer of I.M.S. officers to British Armed Services. It was the Committee's view that this could be equitably effected only on the understanding that there would be no interference with the vested rights to the maximum career of the permanent officers in the Services accepting transfer of I.M.S. officers. If this view were accepted, it must follow that these Services could not offer the same opportunity for a maximum career for those I.M.S. officers who transferred to them. The Committee also wished to know if it was proposed that the Indian Government would accept responsibility for the payment to officers who transfer to British Services of the amount required to bring the pension earned in that Service up to the sum of the pension to which they would have been entitled in the I.M.S.

The C.R.O. stated in reply that I.M.S. officers with up to 20 years' service would be accepted by the three British Services, subject to individual suitability, and then only if they could be offered an adequate career. I.M.S. officers who were transferred would be treated in the same way as officers already serving. An officer who is transferred to the medical service of one of the U.K. Forces will receive one-quarter compensation and will have his reckonable service in the I.M.S. reckoned as service for British retired pay on eventual retirement. In addition, the special element of pension carried by service in India—i.e., the Indian element—will be assessed as on Aug. 15, 1947, or the date of the officer's transfer if before that date, and the amount due will be payable in addition to the pension granted under the regulations of his new Service. That is, he will receive on final retirement the pension or proportionate pension earned by service in the I.M.S. increased by subsequent service in the R.A.M.C. or other Service. For example, an I.M.S. officer aged 35 with 10 years of reckonable service in India will on transfer to the R.A.M.C. or other Service receive £1,125 (1/4 of £4,500), and, assuming that he finally retires from the British Service after a further service of 20 years, his pension on final retirement will consist of a pension based on 30 years' service in the R.A.M.C., etc., plus the specific Indian element of pension earned by 10 years' service in the I.M.S.

The C.R.O. regretted that no possibility could be seen of H.M. Government or the new Governments in India being prepared to accept liability for bringing the combined pension finally payable up to an amount for which an officer might have qualified had he continued to serve in the I.M.S. up to the date of final retirement.

Transfer of I.M.S. Officers to H.M. Civil Services (including the Colonial Service)

The Committee drew attention to the dissatisfaction which had been expressed at the terms offered to officers who elect to be transferred to other Crown services, particularly the Colonial Medical Service. According to the White Paper such officers would forfeit compensation and receive only a resettlement grant of £500, while there was no guarantee that a transferred officer would enjoy seniority in his new service based on his service in the I.M.S. In the Committee's view officers transferred to Crown service should either (i) receive compensation in full, or (ii) receive full credit for all their service in the I.M.S. when their seniority and rate of contract pay in the new service are determined.

In reply the C.R.O. stated that so far as the Colonial Medical Service was concerned the point referred to in (ii) was already under examination, and they undertook to inform the Committee when a decision had been reached. With regard to pension, an officer appointed to a permanent pensionable post in one of H.M. Civil Services (including the Colonial Medical Services) will receive from the date of his retirement from Indian service the pension or proportionate pension earned by him during such service, to be drawn in addition to the pay of his new service, and he will begin to earn a separate pension in his new service from the date on which he joins for duty. Any officer who obtains an appointment under the Crown which is not permanent and pensionable, or who enters the services of one of the Dominions, will remain eligible for the full amount of compensation admissible.

The Committee is seeking an assurance from the C.R.O. that an officer's full service will in fact be taken into account by all Crown services to which I.M.S. officers may be transferred.

Transfer of I.M.S. Officers to the National Health Service

The Committee requested a ruling on whether an officer who accepted an appointment in any National Health Service would be liable to forfeit his compensation and receive only the resettlement grant of £500.

In reply the C.R.O. stated that full compensation would be paid to I.M.S. officers who accepted appointments with Regional Hospital Boards, local executive councils, or local health authorities so long as these were not regarded as permanent pensionable posts under the Crown.

The Committee is not satisfied that service in any National Health Service might not at some future date be held to be permanent pensionable service under the Crown, and foresees the possibility that an officer joining the new Service might subsequently be asked by the Treasury to refund the amount of compensation received in excess of £500. The Committee received no assurance that such an eventuality would not occur and is pressing the Ministry of Health for this assurance.

Leave Pending Retirement (under Military Rules)

The Committee asked for information on the policy of converting home leave into leave pending retirement, which in some cases has deprived officers of 4 to 6 months' leave. In the Committee's view it was thought reasonable that leave pending retirement should in all cases be dated from Aug. 15, 1947, or at least from the date on which the officers were notified that their services were no longer required.

The C.R.O. explained that all I.M.S. officers in military employment on leave at the crucial date had been offered the choice of returning to India for further service in that country or Pakistan, or of having their present leave converted into leave pending retirement. The C.R.O. defended this action by explaining that an officer was not permitted to take ordinary leave in the U.K. except on the assumption that he was returning to India, while the military rules provide that the 12 months' leave which may be granted pending retirement shall include the privilege leave standing to the officers' credit. Further, officers who declined to return to India were given the opportunity of going on leave pending retirement, dating from the commencement of their leave, or of going on release leave from Aug. 15, 1947—i.e., 56 days plus one additional day for every month of overseas service at appropriate Indian rates of pay.

Review of Pensions

The Committee urged that the pensions of I.M.S. officers be revised, particularly in regard to the assessment of proportionate pensions.

To this the C.R.O. replied that approval had been given to the revision of I.M.S. pensions, and new rates, consisting of those contained in the 1945 Pension Code for medical officers of the Navy, Army, and Air Force, with an additional Indian element, are now payable to officers of the I.M.S. If, however, in certain cases it would be more favourable for an officer that his pension be assessed on the old code, this would be done.

Additional Pensions to Officers of the Rank of Colonel and Above

The Committee urged that the regulations for the grant of additional pensions to officers of the rank of colonel or above should apply to officers who held temporary rank of colonel and above for the necessary period during the war.

The C.R.O. stated that it had been agreed that officers pensioned under the new code should receive increased pension in respect of paid acting or temporary service in a rank higher than their substantive rank on retirement, and that in the case of officers pensioned under the old scale substantive lieutenant-colonels who had held the acting or temporary rank of colonel with pay as administrative colonel should be eligible for additional increments of pension in respect of such rank.

Compensation Awards

In answer to specific questions on the mode of payment of compensation the Committee was informed by the C.R.O. that considerable progress had been made in the payment of awards, and an assurance was given that those outstanding would be dealt with as quickly as possible. All grants of compensation will be free of United Kingdom income tax, and it is unlikely that any payments will be made in India.

INSURANCE ACTS COMMITTEE

A meeting of the Insurance Acts Committee was held on Dec. 4. Dr. E. A. Gregg was unanimously re-elected to the chair. The Scottish Subcommittee and the Rural Practitioners' Subcommittee were reappointed, and also the Insurance Acts Committee's nominee on the Ministry of Health Distribution Committee.

Much of the meeting of the Committee was concerned with the resolutions of the recent Panel Conference. These were considered one by one and appropriate action taken. Resolutions which referred to rural practice were referred to an early meeting of the Rural Practitioners' Subcommittee. Other resolutions were noted for further discussion with the Ministry. On the question of ensuring proper representation by co-option of medical practitioners on statutory health committees of local authorities it was stated that the Minister was fully with the profession on this matter. He would be informed of cases in which committees had failed to make such co-option.

A statement was made on the agreement with the Ministry of Fuel and Power concerning the use of petrol by members of the medical profession. The statement appeared in the *Supplement* of Dec. 6 (p. 132). The Committee accorded a vote of thanks to Dr. Wand, chairman of the General Practice Committee, and to Dr. Stevenson, assistant secretary, for their efforts in this connexion.

The position of medical members of local executive councils in relation to the provision of payment for loss of remunerative time in attending meetings of such councils was raised. The experience in this respect concerning members of the insurance committees appears to be diverse, but medical members of executive councils will be more numerous, and a new policy may be indicated. It was agreed to offer no advice to individual members with regard to such claims, but to deal only with the scale of payment allowed.

The future position of the Insurance Acts and General Practice Committees upon the inception of the National Health Service Act was briefly considered, and members were appointed to discuss the matter with members of the General Practice Committee and the Organization Committee.

It was reported that the sessional fee for part-time regional medical officers had been raised to three guineas for a session of two hours, with effect from Oct. 1 last.

The question of medical records of persons no longer entitled to medical benefit was considered on a letter from the Ministry of Health. The Ministry feels that it will not be possible in any new service to revive the old insurance medical records, and in view of the fact that these are at present occupying valuable space it is proposing to advise insurance committees that they may dispose of the records in question. Several members of the Committee expressed the view that an effort should be made to prevent destruction of these records, but eventually it was decided to ask that current records should not be withdrawn from doctors, the Ministry being left to make the decision regarding old records.

Dr. J. W. Bone, treasurer of the National Insurance Defence Trust, reported that during the last twelve weeks a sum of £46,000 had been received—a record income for such a period. The total amount in hand had gone up to just upon £450,000. He mentioned significantly large contributions recently made from some areas.

The Home Office announces that Dr. Brendan O'Carroll, of South Kensington, London, S.W., is no longer authorized under the Dangerous Drugs Acts to be in possession of or to supply dangerous drugs.

PSYCHIATRY AND THE NATIONAL HEALTH SERVICE

A conference of the Psychological Medicine Group was held at B.M.A. House on Nov. 11, principally for a discussion on psychiatry and the National Health Service. The conference, at which there was a large and representative attendance, was presided over by Dr. W. G. Masefield (Eastbourne).

Dr. W. Rees Thomas, of the Mental Health Division of the Ministry of Health, addressed the meeting on the representation of psychiatry generally in the National Health Service. He pointed out that it had been secured in the Act that a certain proportion of members of the Central Health Services Council and the Regional Hospital Boards should be representative of the mental health services. Two of the fifteen medical practitioners on the Central Health Services Council were to be selected for their knowledge of mental illness and mental defectiveness. In all these bodies, including hospital management committees, it was specifically laid down that there should be consultation with the organizations concerned, and in the case of the management committees with the senior medical staff of the hospital, before appointments were made.

In a circular sent to local authorities it had been suggested that they and Regional Boards should make arrangements for some overlapping of staff; unless there was such co-operation the staff shortage would be accentuated. On child guidance he thought the view was accepted that there must be some division of authority; education authorities would continue to have their child-guidance centres, to which if necessary psychiatric advice might be forthcoming from the regional staff. The view of the Ministry was that at the child-guidance centre the visiting psychiatrist would attend only for diagnosis and perhaps short-term treatment. Any child in need of more than that would be dealt with at the child-guidance clinics established under the Regional Board.

Functions of Regional Boards

Dr. Rees Thomas said that development of the mental health services had naturally been unequal in different areas, and it was not expected that the new health scheme would "spring fully armed" on July 5, 1948. Practitioners would presumably draw on the specialist service for consultations in the home. This service was already being carried on by some local authorities. Out-patient departments were slowly developing. There were some 200 adult clinics in the country, some almost entirely diagnostic, others not working frequently. Such activities ought to be one of the first developments of regional mental health services. As for in-patients, there were seven or eight categories of places in which they might be received: first, the mental hospital, the background of the mental health service; then the general hospital, in which, it was hoped, the psychiatrist would have a larger part to play.

Professors of psychiatry at the teaching psychiatric units, like other people who taught, must have beds. At some time in the future each university centre would have a psychiatric unit, with beds for teaching and facilities for research and for postgraduate training. It was expected that there would be a neurosis centre in each region large enough to justify the appointment of a first-class staff. Poor Law accommodation was the worst, but it included places for more than 10,000 people who would come within the care of the Regional Boards as cases of mental illness requiring care and treatment. For this purpose it would be necessary to take over a number of former Poor Law institutions, and in this connexion he hoped that old people would receive special consideration and treatment. What he had said about mental illness applied also to mental deficiency.

Attitude of Lay Public

Dr. J. E. Nicole (a member of the Liverpool Regional Hospital Board) said that behind the question of policy was the question of the attitude of the community towards psychiatry and mental hospitals. To a large extent the establishment of the new Service would rest with the lay community, and the general attitude of that community would determine its character. The stigma of mental illness still lingered. For example, the person to whom it fell legally to commit a patient to a mental hospital was a magistrate, a figure associated in the public mind with delinquency. In a new and much extended mental health service there might grow a tendency, already present to a certain extent, to deal with public prejudice against mental illness, certification, and mental hospitals by means of compromise, circumvention, and appeasement, with disastrous results to psychiatry and to the patients committed to its care. Such a tendency should be vigorously resisted as being inconsistent, medically unsound, and intellectually dishonest. To fight public bias and ignorance rather than appeasing it would be the only way to ensure that patients would be treated and classified on purely medical grounds and not in a manner designed to find an easy way out of the difficulties created by social prejudice.

Dr. Nicole wondered whether those interested in mental health had done all they could to educate members of town and county councils and public-assistance committees in the aspects of mental illness as they knew them. It was very necessary, in the disposal of in-patients, to avoid any indiscriminate classification and to oppose any policy of mere avoidance of mental hospitals. Attention must also be paid to rehabilitation in its broadest sense, remembering that adequate facilities for this might be extremely difficult to provide in some of the psychiatric units envisaged in the new Service. The new Service should afford an opportunity to overcome lingering prejudices and obsolete ideas on the subject of mental disorder instead of pandering to them.

Hospital Management Committees

The conference then turned to questions. The first concerned hospital management committees: would there be psychiatrists on them, and if so would the psychiatrists be of medical-superintendent standing or "some dubious psychiatrist down the street"? Dr. Rees Thomas referred the questioner to the third schedule of the Act, which laid it down that the members should include persons appointed after consultation with the senior medical staff.

On a further question he said that child-guidance clinics which belonged to the local education authority would remain. Other clinics might come within the definition of voluntary hospitals. But he pointed out that if the education authorities undertook the full treatment of children suffering from maladjustment they would be doing it at the cost of the local authority, whereas it might be done regionally as part of the National Health Service.

Asked to what extent the local authority would continue to develop its services, Dr. Rees Thomas said that the answer must be left to different areas. There were a large number of local authorities and a small number of Regional Boards, and the position would differ according to circumstances. Local authorities, if they wished to do so, could employ their own psychiatrists; this was in fact being done by London. It was a matter for arrangement between the authorities and the Boards. What would happen to part-time psychiatrists he did not know. Much depended upon the definition of specialists which the new Spens Committee might formulate in its report. In reply to a question as to the functions of local authorities, he said that one was the prevention of illness, which was a matter of education. It was not, strictly speaking, for the local authority to undertake the education of its local practitioners; the only people to do that were the psychiatrists employed by the Regional Board.

Dr. I. H. Jenkins asked to what extent the membership of the Board of Control would be reinforced by experts in branches of psychiatry other than mental defect or psychosis. Dr. Rees Thomas replied that there were at present four vacancies on the Board, which furnished opportunity for such reinforcement.

Private Work

A question whether a specialist in psychiatry might also do private work was answered from the chair by the remark that the specialist could apply to be put on part-time employment. Another question was whether a doctor running a hospital psychiatric clinic as well as doing general practice would be allowed to continue both jobs under the Service. A member of the Secretariat stated it would be possible for a practitioner undertaking general medical services to undertake at the same

time part-time consultant or specialist duties in contract with a Regional Hospital Board; it was clear, however, that full-time participation in the Service as a consultant or specialist would exclude the right of private practice. It was considered unlikely that a practitioner joining the Service would be eligible for compensation in respect of the income of that part of his practice which derived from consultant or specialist work.

A member wished to know whether it was permissible for the medical superintendent himself or one of his staff to be on the hospital management committee. The chairman pointed out that the management committee of each hospital was appointed after consultation with the senior medical staff. Personally he thought it would be a very invidious position for a medical superintendent to be a voting member of the management committee of his own hospital or institution, although, as Dr. Rees Thomas remarked, there was nothing in the Act to prevent it. Dr. Rees Thomas also thought that in certain provincial regions it might not be possible always to find psychiatrists for membership of management committees other than those fully employed by the hospital.

On the question of a revision of the Lunacy Acts, Dr. Rees Thomas said that it was agreed that as soon as Parliamentary time allowed a new Act should be brought before the House of Commons. In reply to a question about ascertainment, he said that this was a general-practitioner service, but so far as children were concerned it was suggested that where there was any doubt the authority ought to call in a specialist for advice on the mental condition. Finally, asked about funds likely to be available for psychiatric research, the chairman referred to Section 16 of the Act, which gave power to the board of governors of a teaching hospital, a Regional Hospital Board, and a hospital management committee to conduct research into the causation, prevention, diagnosis, or treatment of mental illness or defect.

HEARD AT HEADQUARTERS

From Down Under

The bulky minutes of the Federal Council of the British Medical Association in Australia, held at Melbourne recently, are before me. They do things strenuously in Australia. The meeting of the Council lasted three days, and on two days went on until ten at night. Of the seventeen members the fourteen who live outside the State of Victoria, where the meeting was held, must have travelled a total of something like 20,000 miles to attend and return to their several States. One of the big questions at issue concerns the conversations with the Minister for Health about a free medical service—in particular on this occasion the method of payment of general practitioners in such a service. In the Federal Council the method which found most acceptance was fee-for-service, though the capitation method had its advocates. A salaried service was deprecated by everybody, but it was said that this, although favoured by the Government, was not a practical issue, because the Prime Minister had stated that there were not enough doctors to carry it through. The salaried method involves the intervention of a third party, which destroys the doctor–patient relationship, and the basic salary plus capitation-fee method was considered the worst of all because it embodied the evils of both systems. It is not very clear from the discussion what the evils of the capitation system are supposed to be, except that one member said that it meant for the doctor an unknown quantity of work for a known fee, and thus kept him under continual obligation for the same reward. At all events it was resolved that the correct method of payment for general practitioners in a National Medical Service in Australia is fee-for-service. The Federal Council reaffirmed the seven principles which the parent body in Great Britain has laid down as governing a national service.

Perpetual Chairmen

The first act of the Insurance Acts Committee—which is threatened with death and resurrection—the other day was to re-elect Dr. Gregg as its chairman. In the more than thirty years' history of that committee it has had only four chairmen—the late Dr. (afterwards Sir Henry) Brackenbury, Dr. Dain, Dr. Jonas, and the present occupant.

Correspondence

National Health Service

SIR,—Within a few weeks groups of the profession will be considering the final reply of the Health Minister to our Negotiating Committee on the New Health Act. As a convener of one of those groups I would welcome some general professional agreement on basic principles to guide our discussions; and to stimulate suggestions from others I submit the following, making no claim that they exhaust the subject.

(1) We desire to extend the benefits of modern medicine to all citizens regardless of their financial status, due consideration being given to the requirements of professional efficiency and economy.

(2) Since we do not now inquire from patients whence they derive the money which remunerates us for services, neither should we do so in the new Service. So long as the remuneration per patient satisfies us, we need not as doctors be concerned with whether or not H.M. Government makes a compulsory levy on all citizens to meet the Service cost. That is a matter for citizens as citizens; we also would decide on it only as citizens. It does not concern us *professionally*.

(3) We should consider the organization of the proposed Service from the doctor–patient end, as these are primarily and finally the interested persons. That is, we should consider organization from the periphery up to the Ministerial level and not vice versa, accepting only those elements of organization which assist towards the fulfilment of the general aim of the Service as expressed under No. 1 above.

(4) There shall be *two-way* absolute free choice between doctor and patient. The doctor shall be responsible primarily only to the patient for the quality and nature of his service, though penalty for alleged delinquencies of doctors should be determined by a recognized committee or body (perhaps the local executive councils) after investigation of complaints *under oath*, and subject to appeal to the judicial courts of the land—not to the Minister. Gestapo "tribunals" are rejected.

(5) The general practitioner to be the keystone of the whole service in view of the fact that he is the commando, shock, front-line attack in the battle against disease and illness and that no "back line" of hospital or specialist will be of avail in the fight if the G.P. is relegated to the role of first-aid man or "pillar-box" for the posting of a patient to unnecessarily subdivided and over-multiplied "specialist" services. The G.P. to have available laboratory, *x*-ray, and other ancillary aids to diagnosis and free choice of regional or, where necessary and justified, national specialists for the benefit of his patients. The G.P. professional status to be raised, not depressed.

(6) The medical service to be considered essentially as a unity. For the efficiency of medicine and the interest of the public we must not allow the individual patient to be caught in the ill-conceived tangle of antenatal, after-care, and school clinics, and maternity, home-nursing, health-visiting, midwife, hospital, and other services, all working in more or less watertight compartments, each having only a loose and cumbersome and frequently dangerously uncoordinated liaison the one with the other. For example, midwifery: as every woman may under the Service desire now to consult a doctor as soon as she becomes pregnant, every G.P. should be recognized as free to undertake antenatal care of his patient should she so elect and to follow her through her puerperium and confinement, seeking specialist obstetrician or gynaecologist if he considers this to be necessary, but having constantly (if the case remains in his care) at his direct call the services of midwife, general-nursing, laboratory, and other necessary services; a panel of those electing to do midwifery being formed in each area, from which the expectant mother be free to make her choice. Obstetric specialist teams, of course, would be available from each hospital or other centre to deal with urgent non-transportable cases where for any reason adequate hospital provision had not been made for abnormal cases beforehand. Likewise, school clinics dealing with a child while it remains ambulatory only to hand it over to the home doctor when confined to bed are futile and should be abolished. *Mutatis mutandis*, similar considerations to be applied to other services.

(7) Every care must be taken to ensure adequate representation of the views of the profession and the protection of the rights of its members at every stage of the organization to be set up.

(8) Adequate payment on a capitation basis (with mileage allowance where applicable) to be recognized, and contracts of service to be with local bodies such as the local executive councils. A basic-salary element to be entertained only to attract doctors to an area without doctor or to one inadequately supplied for some reason or other. There should be no Ministerial or other "direction" of doctors.

The above are put forth as minimum basic requirements from a general-practitioner point of view. Many other considerations such as advance of the G.P. to specialist status must be kept in review; but the foregoing are minimal requirements, and I for one shall conduct my study group with these in the forefront and shall advise rejection of the Service if it does not fulfil each and all of these minimal requirements.—I am, etc.,

Shrewsbury. W. J. GRANT.

Working Hours in the N.H.S.

SIR,—The worshippers of the god of things-as-they-are appear to be very concerned about the increase of work which, they say, is certain to follow the introduction of the National Health Service. They are also concerned, and have been for years, about the constant decrease of the G.P.'s work due to the encroachment of hospitals, clinics, babies' welcomes, and so on. Would it be asking too much for them to decide which of these two things they really fear?—too much work or too little? It is so confusing when they try to have it both ways.—I am, etc.,

Morley, nr. Leeds. W. STANLEY SYKES.

The N.H.S. and Compensation

SIR,—Many practitioners will share the concern expressed in Dr. D. W. Mayman's letter (Nov. 29, p. 127) that the vitally important question of compensation for loss of goodwill has not been discussed with the Minister. If it is to be discussed, may I suggest that the data upon which the global sum of £66,000,000 has been based are grossly out of date. Since 1938, the year in which these data were collected, the cost of living has greatly increased, and the gross income of most practices has also risen. If compensation is to be paid it should be adequate and fair and should not be based upon a computation arrived at when the pound was worth three times what it is to-day.—I am, etc.,

Filey, Yorks. E. W. VINCENT.

The Doctor's Wife and the N.H.S.

SIR,—At present the average general practitioner maintains with his wife a reasonably efficient medical service for a considerable number of persons in the community. Most general practitioners and their wives are content to work as a team. The doctor's wife in the majority of cases has a remarkably accurate knowledge of her husband's patients, and without her aid very few medical practices could exist, especially in these days of domestic-help shortage.

I feel that insufficient attention has been paid to the work at present conducted by the doctor's wife and would suggest that a questionary be sent to all doctors' wives asking whether or not they are willing to work a 24-hour day for no remuneration. The doctor is to be nationalized, but his wife is not. Who therefore is to perform the work carried out just now by his wife? It would appear that if the proposed National Health Service is to work efficiently each doctor will have to be provided with a secretary-receptionist to answer telephone and door bells and attend to his correspondence. But as the doctor must be on call for 24 hours per day actually three secretaries would be required if each were to work an 8-hour day.

I feel that if all doctors' wives were to say "No" to becoming unpaid Government servants then the proposed Health Service would collapse in about two weeks.—I am, etc.,

Clydebank. A. H. MILLER.

Remuneration

SIR,—Earlier in the year I was informed by the county health authorities that general practitioners would be paid at the rate of £2 5s. per session of 10 tonsil anaesthetics, a rate of 5s. per case instead of the 7s. 6d. which obtained before this new rate came into force. I have also been recently notified by the same authority that each antenatal examination will be paid at the rate of 12s. 6d. per attendance, an advance of 7s. 6d. on the old rate of 5s.

The fees payable for the two items are vastly disproportionate and in inverse ratio to the skill and time required for these different types of work. It may be that the world is now in a state of topsyturvydom and that the medical profession is expected to accept things the wrong way up. I trust that the B.M.A., who have had a hand in negotiating the tonsil-anaesthetic fees, will not expect general practitioners to stand on their heads to see things in their proper perspective; and I hope still more that in the present negotiations with the Government this is not the vertical position we shall be required to assume should it become necessary to oppose certain Government proposals.—I am, etc.,

Blakeney, Glos. J. ASHTON.

*** The Secretary of the B.M.A. comments: The fees negotiated by the B.M.A. with the associations of local authorities for professional work (including the administration of anaesthetics) are £4 4s. for specialists and £2 5s. for general practitioners, for sessions of normally 1½–2½ hours. For antenatal and post-natal examinations the agreement lays down a fee of 7s. 6d. for each examination and a fee of 12s. 6d. where a report is also requested by the local authority. A "no detriment" clause in the agreement safeguards the position of practitioners who may be receiving fees in excess of those agreed.

Working Conditions for the General Practitioner

SIR,—May I once again be granted space to champion the cause of better working conditions for G.P.s? Under present conditions doctoring in a busy panel practice at the height of the winter is an absurdity. Even in an eleven-hour working day the average time it is possible to allot to each patient during surgeries is 2–4 minutes. Likewise for visits, it is 10–15 minutes *including* travelling time from house to house. Added to this pressure of work, the strain of after-dinner, night, and Sunday calls leads to progressive tiredness, and it is a miracle that more and bigger and better errors of judgment are not made more often. It speaks highly of the ability of the G.P.

These facts I believe to be irrefutable, and they are at times an understatement. The result is that we dread our work instead of enjoying it, not merely because of overwork but also because of the lack of the surety of leisure. These conditions are partly due to underpayment of doctors and could be remedied by an adequate basic salary in the N.H.S. But are they not also partly of our own making and the result of competition instead of co-operation, and to overlapping and maldistribution and malutilization of medical personnel?—I am, etc.,

Englefield Green, Surrey. W. E. R. BRANCH.

Tuberculosis Administration

SIR,—Dr. H. J. Trenchard (Nov. 22, p. 121) has defined correctly the category of the officers considered by the Joint Tuberculosis Council to be necessary for tuberculosis work in the regions. The memorandum of the Joint Tuberculosis Council on the "Organization of the Tuberculosis Service under the National Health Service Act" reads:

> In the view of the Council the essential co-ordination at regional level of the tuberculosis service cannot be ensured unless each region has on its staff an administrative tuberculosis officer of the Tuberculosis Committee whose establishment is recommended above, and we suggest that one of the appointments by the Board should be that of Regional Tuberculosis Physician, who should possess administrative experience of a high order as well as clinical ability at specialist level.

The "co-ordination" referred to must include not only liaison between clinic, institution, and local-authority services but an effective system of training and promotion. The Council believes that this can best be provided by the formation of clinical teams. This system has operated successfully in a number of areas in the past and has also achieved eminence in the larger teaching hospitals. No complaint of control has ever been received, and there is no reason why the system if applied to the new Service should give rise to misgiving.—We are, etc.,

D. P. SUTHERLAND, Chairman,
Joint Tuberculosis Council. N. J. ENGLAND, Hon. Secretary.

The Home Office announces that the Authorities granted by the Regulations made under the Dangerous Drugs Acts, 1920, have been restored to Dr. Alex Forbath.

Association Notices

SCHOLARSHIPS IN AID OF SCIENTIFIC RESEARCH

The Council of the British Medical Association is prepared to receive applications for Research Scholarships as follows: An Ernest Hart Memorial Scholarship of the value of £200 per annum, a Walter Dixon Scholarship of the value of £200 per annum, and four Research Scholarships each of the value of £150 per annum. These scholarships are given to candidates whom the Science Committee of the Association recommends as qualified to undertake research in any subject (including State medicine) relating to the causation, prevention, or treatment of disease. Preference will be given, other things being equal, to members of the medical profession.

Each scholarship is tenable for one year starting on Oct. 1, 1948. The scholar may be reappointed for not more than two additional terms. A scholar is not necessarily required to devote the whole of his or her time to the work of research but may hold an appointment at a university, medical school, or hospital, provided the duties of such an appointment do not interfere with his or her work as a scholar.

In addition, applications are invited for the first award of the Insole Scholarship of the value of £250 for research into the causes and cure of venereal disease.

Conditions of Award : Applications

Applications for scholarships must be made not later than Friday, April 30, 1948, on the prescribed form, a copy of which will be supplied on application to the Secretary of the Association, B.M.A. House, Tavistock Square, London, W.C.1. Applicants will be required to furnish the names of three referees who are competent to speak of their capacity for the research contemplated.

Branch and Division Meetings to be Held

MARYLEBONE DIVISION.—At 26, Portland Place, London, W., Tuesday, Dec. 30, 8.30 p.m. Agenda: report by Representatives on A.R.M., July, 1947; report by Lord Horder and Mr. Lawrence Abel on negotiations with Minister of Health; discussion of the following motion, "This Division deeply deplores the refusal of the Minister to accept the fundamental principles of the profession and to introduce amending legislation to the National Health Service Act, 1946. Accordingly this Division requests that, before the plebiscite, the B.M.A. Council will give the strongest possible lead to the profession not to accept service under the Act"; consideration of size of support required for successful opposition to the Act.

SHROPSHIRE AND MID-WALES BRANCH.—In Ballroom of Raven Hotel, Shewsbury, Sunday, Jan. 4, 2.30 p.m. General meeting. Agenda: Discussion on National Health Service as finally decided upon by the Minister; Instructions to Representative prior to Representative Meeting in London. All medical practitioners in the area of the Branch are invited.

WINCHESTER DIVISION.—At Nurses' Home, Royal Hampshire County Hospital, Winchester, Sunday, Jan. 4, 11 a.m. Extraordinary General Meeting. All medical practitioners in the area of the Division are invited.

Meetings of Branches and Divisions

KENT BRANCH

A meeting was held on Oct. 24, with Mr. W. E. C. Wynne presiding. Those present were Drs. G. R. F. Stilwell, F. C. Cozens, A. D. Broatch, P. Jacob Gaffikin, H. J. Hoby, A. V. Kelynack, R. Prosper Liston, G. E. M. Meyer, G. C. Milner, E. G. Pringle, M. F. Prout, A. Talbot Rogers, D. M. Thomson, and J. O. Murray, and Mr. A. R. Jordan.

A letter from the honorary secretary of the Kent Area Committee, British Hospitals' Association, pointed out that the Kent Area Committee had passed the following resolution: "That this Special Committee (of medical representatives) of the British Hospitals' Association recommends the B.M.A. Council to consider the formation of a special subcommittee of the Branch Council (with appropriate representatives to be elected by hospital medical staffs) to deal at a county level with matters affecting hospital medical staffs." It was resolved that this resolution be approved and that a special subcommittee be set up, and that it consist of Mr. W. E. Heath, Dr. F. C. Cozens, and Dr. A. Talbot Rogers.

Dr. Talbot Rogers explained that the local medical and panel committee was the authorized body recognized by the K.C.C., and that so far the K.C.C. had decided not to co-opt medical practitioners. It was resolved that all steps be taken as an endeavour to obtain co-option of medical representatives on the Kent County Council Health Committee.

It was resolved that Mr. A. R. Jordan and Mr. W. E. Heath be appointed representatives of the Kent Branch Council on the South-eastern and South-western Metropolitan Hospital Areas (Cancer Service (Cancer Act, 1939)).

NORTHERN IRELAND BRANCH

A meeting of Branch Council of the British Medical Association, Northern Ireland, was held on Nov. 6, with Dr. T. A. Kean in the chair. Members present were Drs. Kean, Warnock, Boyd, Lyle, Boylan, Halliday, Andrews, Pyper, Hadden, Clarke, Smiley, Bereen, Giff, Hemmingway, Hunter, Crozier; Messrs. I. Fraser and H. I. McClure.

Dr. Lyle inquired if the university members of Parliament had tabled the motion in the House of Commons in respect of the Topping Report. Dr. Halliday stated that on the advice of counsel this motion had been postponed and that a new clause had been drafted by counsel to be inserted after Clause 45 in the Health Services Bill to read as follows:

"The Ministry may prescribe the qualifications, remuneration and conditions of service of all or any of the officers of a health authority employed for the purposes of its functions as a health authority provided that in the case of a professional officer the Ministry shall consult such organizations as may be recognized by the Minister as representing the profession concerned."

In the past the Minister had always deplored the fact that he had not power to dictate to local authorities and other bodies. If this clause was accepted by the House and the Minister still refused to implement the Topping Report then the university members would bring forward their motion and have the whole question discussed in the House.

Dr. Halliday stated that it was of the greatest importance that a negotiating committee should be formed to meet the Minister to discuss the Regulations arising out of the Health Services Bill. This committee would not have power to commit the Association but would report to Branch Council, who would in due course seek confirmation of the Association. Discussion followed and it was agreed to nominate one general practitioner, one public-health officer, and one consultant or specialist from each Country Division. It was left to the discretion of the Divisional committees concerned whether these nominations were made by them or at a meeting of the whole Division. Dr. Hunter suggested that in the case of the Country Divisions where travelling distances would cause serious inconvenience due to petrol restrictions, etc., a Division could nominate members from another Division to act on their behalf. The Belfast Division owing to their much larger numbers would nominate four members from each group of the profession.

Dr. Crozier stated that the marriage bar imposed on women employed by the Northern Ireland Government had been discussed and a recommendation reaffirming the policy of the Association that in considering grounds for the appointment or dismissal of women medical officers marriage should not be made the reason for withholding or terminating an appointment. It had been agreed that a copy of the resolution should be sent to the Northern Ireland Government and to the Glasgow Corporation, which also adhered to the marriage bar.

PRESTON DIVISION

A B.M.A. Lecture was delivered on Dec. 9 by Prof. Ian Aird, of the London Postgraduate Medical School. Over seventy members were present, and Dr. W. A. Simpson, Chairman of the Division, occupied the chair.

Speaking on "Gastro-duodenal Haemorrhages," the lecturer declared that in such a condition where both physician and surgeon were concerned the importance of close team-work could not be overstressed. Careful selection of cases for operation was of the utmost importance. While operation should be resorted to only in cases where success was likely, it should not be used in cases which would recover under medical treatment. Referring to Meulengracht's exceptionally low mortality figures, he suggested that they might be accounted for by the inclusion of cases which did not in fact require operative treatment. In cases over 45 a second haemorrhage was an indication for operation, though older patients were bad operative risks. Local analgesia was recommended, though in younger patients gas-oxygen and cyclopropane might be used.

In determining operability the height of the blood urea was important and should always be estimated. Experiments on medical students who had blood poured into their stomachs by stomach tube showed a raised blood urea in these cases. This indicated that the mere presence of the blood in the stomach was a factor in the raised blood urea in haemorrhage cases.

A vote of thanks was proposed by Mr. Arnott and seconded by Dr. D. J. Davies.

TRADE UNION MEMBERSHIP

The following is a list of local authorities which are understood to require employees to be members of a trade union or other organization:

County Borough Councils.—Barnsley, Gateshead.

Metropolitan Borough Councils.—Fulham, Hackney, Poplar.

Non-County Borough Councils.—Dartford, Leyton, Radcliffe (limited to future appointments), Tottenham, Wallsend.

Urban District Councils.—Denton, Droylsden, Houghton-le-Spring, Huyton-with-Roby, Portslade, Redditch (restricted to new appointments), Stanley (Co. Durham), Tyldesley.

Scottish Burghs.—Motherwell and Wishaw.